

Ethical problems with kindness in healthcare

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ABSTRACT

Kindness and its kindred concepts, compassion and empathy, are strongly valued in healthcare. But at the same time, health systems all too often treat people unfairly and cause harm. Is it possible that kindness actually contributes to these unkind outcomes? Here, I argue that, despite its attractive qualities, kindness can pose and perpetuate systemic problems in healthcare. By being discretionary, it can interfere with justice and non-maleficence. It can be problematic for autonomy too. Using the principlist lens allows us to visualise kindness more clearly and to dissect out its key qualities. Ideally, kindness should be not just beneficent but also respectful of the person, fair and non-maleficent. I use examples to illustrate the adverse impacts when kindness runs short on each. Finally, I propose that we can improve on this, by diversifying our approach to inclusion. Outgroups should be more included, as a way to mitigate discrimination wrought by discretionary kindness. But we can do better. Ingroup health professionals too often sit 'above the fray'. They should also be more included, but now as research subjects, so we can understand together how they benefit from discretionary kindness and deftly make it work for them and theirs.

INTRODUCTION

Kindness is commonly reckoned a virtue, but I argue here that it poses ethical problems within healthcare that should be better examined, given the potentials for harm, and also positive reform.¹ I begin by drawing out the features of kindness that appear salient to the ethical challenges. Having characterised it as a form of beneficence, I then examine the problems that kindness can pose to the remainder of Beauchamp and Childress' four principles.² From here, I consider some hazards of reckoning kindness too simply as a virtue. Finally, the inquiry leads on to practical changes we might look to make within both healthcare policy and professions. Key will be a more inclusive take on inclusion.³

On kindness and its kin

Alongside kindred concepts like compassion and empathy, kindness appears to have been long valued within healthcare. The current era has seen this continue, with discourse around compassion becoming particularly prominent.⁴ At an institutional level, compassionate leadership is promoted as better for staff and safer for patients⁵; at a personal level, self-compassion is advocated for staff and patients alike.⁶

Kindness is often used interchangeably with compassion and sometimes the latter, with empathy. For the purposes of this paper, and recognising alternate views, I would relate them as follows. Empathy is that ability to put oneself in another's shoes, feeling something of what that might be

like. Compassion, literally to suffer with, is perhaps more than being in another's shoes; rather it is a feeling that encompasses both shared distress but also a sense of solidarity and even a call to action.

Kindness, then, relates to each of the above but perhaps with more emphasis on action, and less need for this to be in mitigation of suffering. It has perhaps a more prosaic and practical quality than compassion. Clinically, that practical feel may make it easier for patients to consider being kinder to themselves rather than being exhorted toward 'self-compassion'. Practicality aside, kindness can also feel more discretionary than compassion (more to be expected) or empathy (less voluntary).

It may help briefly to expand on this point. Doing someone a kindness can overlap in meaning with doing them a *favour*. The latter bears firm connection to discretionary concepts like *favourite* and *favouritism*. By comparison, the meanings of empathy and compassion stretch less readily toward favours. Rather, empathy can be viewed as more felt than chosen, with compassion the expected reaction. On this account, kindness, being more chosen, is more discretionary. That said, similar considerations could be applied wherever empathy, compassion or other virtues promote beneficent acts: choosing affords more discretion than reacting. For example, the *courage* of choosing to report corruption may be viewed as more discretionary than *courage* that stirs involuntarily on hearing a rousing anthem. In summary, kindness—via its relation to chosen action—bears a discretionary element that is important to what follows.

Kindness and discretion

Kant signalled that kindness has its limits, when he listed charity as an example of an imperfect duty, permitting of exceptions.⁷ This recognises that *kindness* is, at its heart, discretionary. After all, the word shares a root with *kin*, and our *kind*, giving that sense of circumscribed scope. Moreover, attempts to remove the free, discretionary element to kindness would be, in effect, to turn charity into a tax. Even a life-saving act might be better seen, less as kindness, and more as an act under particular obligations such as the *duty of easy rescue*—in which case there is often a strong motivation to mitigate harm.⁸ I maintain that this contrasts with kindness, arguing that, for our purposes, the latter reflects an offer that stems more from generosity, and often without needing the mitigation of harm. An example may help illustrate the point. When my neighbours are on holiday, I might mow their lawn out of a kindness that's generous and unconcerned. However, I would report suspicion that their house is on fire out of a dutiful concern to rescue the situation.



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Looked at in this way, the discretionary element to kindness triggers two key questions: ‘To whom should we be kind; and to what extent?’. I should add at this point, that even if one does not accept that kindness is inherently discretionary and prefers a view that some obligatory acts can nonetheless be performed out of a sense of kindness, the argument that follows requires only that some or most kindness is discretionary.

Kindness and beneficence

The challenge posed above, to delineate the scope and force of discretionary kindness, is a feature shared with beneficence. Indeed, Beauchamp and Childress highlight this important claim: that our duties towards beneficence are more limited in scope and more often discretionary than those toward non-maleficence.² In other words, we have stronger obligations and less freedom when it comes to the avoidance of harm, than we do when considering our duties to help out. This means we have firm duties against unkindness but wide choices to be kind. For our considerations, I would argue that a further similarity between kindness and beneficence is the orientation toward benefit, rather than harm mitigation. I have touched on this in the preceding section (mowing lawn vs reporting fire) and condense the point as follows: the more that the purpose of action is harm mitigation, the more that the act may be seen as obligatory, and the more it tends to our duties toward non-maleficence, rather than what might be termed, in contrast, freely-chosen acts of kindness. In that sense, kindness—at least for our purposes in this discussion—can be characterised as acts borne more of generosity than concern. In this guise, it can be hard to conceive where this might lead to ethical difficulty. But in what follows, I want to suggest that this assumption (of generous and unconcerned kindness) sits behind some significant problems that permeate healthcare and its professions.

Kindness and justice

As explained, my plan here is to proceed with an examination of the areas where kindness can cause ethical difficulty, and to do this principally by examining the potential for conflict with the others of Beauchamp and Childress’ four principles, starting with justice. My argument is that the discretionary element of kindness can lead to situations where kindness for some leaves others out in the cold. In that sense, one could see kindness as a good, where unequal access and distribution leaves some less kindly treated. This can matter deeply, and be poorly understood, even when in plain sight.

A topical example, from beyond healthcare, may help start us off. Recent events have seen mass migration out of Ukraine as people flee the Russian invasion. The response of people in some bordering countries has been lauded for its openness and speed in offering support.⁹ This generosity might be seen as a good example of compassion, with strong hopes to mitigate harm. But at a personal level, it may also be characterised as kindness made more typical by the fact that it is discretionary. Some refugees, typically white Europeans, are welcomed with highly generous sentiment. But it has been noted that such kindness seems to have been less in evidence earlier, towards Syrian refugees.¹⁰ Moreover, black and brown students fleeing Ukraine have reported being sent to the back of relevant queues, as their white fellow refugees are prioritised.¹¹ If we accept this summary, it would be an example of what can be considered an ethical problem with kindness. Discretion can harbour discrimination, meaning that we have to attend not simply to the kind acts, but also to what ‘kinds’ are receiving them, and to what extent. A particular challenge arises: there may be limited appetite to scrutinise this type

of discrimination when the kindness shown to the majority is so powerfully evident and valued. This may make the discrimination far harder to name, let alone tackle.

An example from within healthcare may further illustrate this point. Roger Kline delivered a report memorably titled the ‘Snowy White Peaks of the NHS’.¹² This and his subsequent work have demonstrated how a certain ethnicity dominates in senior NHS positions, this despite generations of participation by highly qualified members of other groups, many UK-trained. Few would suggest this state of affairs exists due to explicit and universal animus toward one or more minoritised groups. But disregard and a lack of kindness may be more relevant. Kline puts it another way, asking that we keep a careful eye for the ‘stretch opportunities’ that may often precede substantive promotion and are sometimes allocated by means of what he terms a ‘tap on the shoulder’.¹³ To those tapping, and those tapped, this may well feel like a network of discretionary kindness, where one good turn deserves another. But to those out-with this system, it may look more like a system of perks for insiders.

This problem seems likely to be sharpest where discretion is the greatest. This would be in areas of work where performance is complex and judged largely on reputation rather than simpler, transparent and more objective means; where reputation is therefore critical to the maintenance of both trust and power. Like the judiciary, the upper echelons of the NHS fulfil these criteria, and are likely to be particularly vulnerable to discrimination via discretionary kindness.¹⁴ That said, the discretionary element may be in play at all levels within healthcare, and in ways that are more obviously relevant to harm.

Kindness and non-maleficence

Leadership that promotes its own kind, while leaving others less heard and less included, could be a significant factor in the failure of services to address glaring health disparities.¹⁵ In this section, I wanted to consider issues like this, where kindness could foster not just unfairness, but other forms of harm, up to and including illness and death.

We can start with a system where discretion may matter greatly: that of professional regulation within healthcare. This is now perhaps a half billion pound per annum industry in the UK, but one that seems repeatedly unable to prevent serious harms and scandals within the NHS.¹⁶ Subject to some forthcoming reorganisation, several entities regulate healthcare professionals and also health institutions. These regulators operate by rules, but in practice the procedures afford them a great deal of discretion. This can mean the difference between a case being dropped at an early stage and smoothed out locally, or being pursued all the way to full hearings against the relevant health professional. Here, I would argue that discretionary kindness can play a harmful role. Hospital directors may be reluctant to press charges against longstanding colleagues and friends, with the result that suboptimal practice may not just linger, but thrive. An example was the dozens of children who suffered avoidable deaths or disability after undergoing heart surgery at Bristol Children’s Hospital. One of the senior surgeons operating beyond his capabilities was Mr James Wishart, but he was also the Medical Director. He and his Chief Executive, Dr John Roylance were both eventually struck off after they failed properly to intervene in the matter and the deaths became public knowledge.¹⁷ Clinical managers of the breast surgeon, Mr Ian Paterson, have similar questions to answer after he was convicted of wounding several women over many years, despite protests from different quarters.¹⁸

We can look at this in a broader way, taking the example of one regulator, the General Medical Council (GMC), and the doctors

they regulate. For some time, it has been recognised that minoritised doctors are at higher risk of becoming enmeshed in GMC proceedings. This point is summarised in a recent legal judgment where the GMC was held to have directly discriminated¹⁹:

BME doctors are 29% of all UK doctors however employers make 42% of their complaints about BME doctors. UK graduate BME doctors are 50% more likely to get a sanction or warning than white doctors. There is a chart produced in the papers we were provided (D181) that illustrates the risk of different types and ages of doctors being complained about and of those complaints being investigated, by ethnicity and place of primary medical qualification, in 2010-2013. This further illustrates the position of adverse position [sic] of BME doctors when compared to white doctors. [BME—black or other minority ethnicity]

The GMC may argue that healthcare employers are to blame, via differential rates of referral. Others may argue that overseas doctors are less familiar with and hence more vulnerable to such processes. However, the higher rate of sanctions and warnings for minoritised UK graduates indicates an issue with GMC processes that cannot so readily be explained away. In response, the instinct can be to focus research on the differential attainment of minoritised doctors.²⁰ But this may be to miss the point, at least in some important respects. So, let us look at this problem again, but from a different angle.

There is a plausible alternate hypothesis that, in fact, white doctors are under-represented in the GMC's disciplinary proceedings; in other words, that the majority group of doctors are underinvestigated. The GMC has an overarching duty to protect the public, so it should be keen to understand if this is the case and whether it stems, in part, from differential kindness shown to majority-group doctors by their peers.²¹

There is ample material for examination. For example, the Paterson case begs questions about why it was so hard to bring a senior white surgeon to book, when minoritised doctors like Dr Bawa-Garba and Mr Sellu seem to have provided far easier prey for their peers, their regulator and the courts.^{22 23} This can help us look beyond *fairness*, and the experience and qualities of minoritised doctors, to examine the more pressing issue of *safety*, and whether the majority of doctors are going underscrutinised.

This matters: after all, inadequate oversight is a theme that runs through UK healthcare failures documented within reports into, for example, Ian Paterson, Gosport War Memorial Hospital and, most recently, Shrewsbury and Telford maternity services.^{16 24 25} In each, oversight was said to have been in place, but in practice there appears to have been a reluctance to apply it. This then allows us to frame the problem as follows: that it can be seen as a kindness to be loyal, and to favour one's own, even if that is at the expense of outgroups such as patients and families. This is not a phenomenon confined to healthcare. Indeed, other high pressure workplaces, such as policing, seem to suffer similar failures, due to the favours afforded ingroup, that keep perceived outsiders at bay.²⁶

Unfortunately, the harms of this approach, both to outgroups, but also to the ingroup, can be significant. In policing, minoritised groups can be stopped, and even killed at higher rates, even as the police involved keep faith with one another.^{27 28} But this can also damage the trust needed by the ingroup in order to do their job. In healthcare, too often patients and families have to do the hard work of raising concerns, investigating and lobbying, only to find that the harm done to them was after all not an isolated incident, but part of a pattern that was routinely downplayed, in part out of a sense of ingroup loyalty and kindness

among healthcare colleagues. As a result, people suffer avoidable and life-long harm.^{16 24 25} For example, the Kennedy inquiry into heart surgery for children in Bristol used the term *club culture* to denote that ingroup approach where the in-kind benefits came at the expense of the children and families.²⁹

Kindness and autonomy

In the preceding section, we considered together how kindness towards our ingroup could harm outgroups. Here, I would like to consider the situation where we explicitly intend our kindness to benefit such outgroups. I argue that kindness remains an ethical challenge, even given ostensible goodwill towards perceived outsiders.

This is perhaps a more familiar problem than those considered in the prior sections. For example, William Easterly wrote trenchantly about the need to look at the evidence for overseas aid interventions—in part as a response to what he saw as a naive view that aid organisations had the right answers and needed mainly to persuade the local populations to come round.³⁰ Likewise, Linda Polman highlighted the perverse incentives that can arise for aid organisations when charity and the necessary fundraising imperatives become entangled.³¹ Both writers critique what we in healthcare would label paternalism: the notion that we know better than others what is best for them. In other words, these are cases in which kindness can infringe on autonomy.

The medical literature features several instances where supposed good intentions were used as justification for coercing others and overriding their wishes. The maternity scandal unfolding at Shrewsbury and Telford speaks to this.²⁵ Reports indicate that there may have been an ideological belief in the benefits of natural child birth and the avoidance of Caesarian section, which led to clinicians pressing this on mothers, even when it turned out to be a poor idea. Looking further afield, the justifications for colonialism can have this paternalistic flavour, with supporters adherent to the view that it helped draw benighted populations into the light.³² Of course, this now competes with a view that such populations were ruthlessly exploited, often with extreme use of force, in order to fill the coffers of the empire and its leaders.³³ Within healthcare in the UK, there is a long history of doctors from former colonies migrating here to fill posts. Though said to be for the benefit of their training, they were often being exploited. The House of Lords admitted the problems as follows, and as early as 1961:³⁴

[Overseas doctors] are coming here to learn, and they are going 'to the worst places to do it, where there is less supervision. They are acting as pairs of hands, usually with very incomplete and inadequate supervision.....Without them, our hospitals would collapse, and we should be proud that they want to come to us and learn. But we are not treating them fairly.

Duties, consequences and virtues

Before closing, I wanted to consider this issue from the perspective of the competing ethical theories. Earlier in the piece, I set out my reasoning for why kindness is inherently discretionary. If we accept that premise, it means a binding 'duty of kindness' could have only a limited scope (as per Kant's view on charity). Alternatively, a consequentialist view has been incorporated in some of the considerations above. For example, we have reflected together on the harmful outcomes that might be wrought by the sort of kindness, borne of 'kin' loyalty, that says 'we favour our kind'. It remains then to say something about kindness as a virtue, as a feature of character rather than action.

As argued above, to think of oneself as kind, or to be thought of as such, could be a route towards injustice, wrong-doing and paternalism. Healthcare professionals are perhaps quite vulnerable to this seductive belief in their own kindness and therefore to the attendant side effects. For example, medical students and experienced doctors ranked kindness as a key virtue for doctors to have, and at the same time confidently assessed themselves as kind.³⁵ In other words, practitioners may view themselves as particularly virtuous—when in fact they may sometimes be seen as quite self-serving.^{36 37} The view that healthcare professionals are virtuous may lead them to feel that they deserve the perks and taps on the shoulder that come their way, but without sufficient reflection that the same kindness goes un(der)offered to others.³⁸ It may lead them also to see themselves as part of a special cadre, where loyalty and ingroup kindness mean that secrets are kept.³⁹ The virtue position can also provide a sturdy pedestal from which to lecture others on their best interests.⁴⁰

Practical conclusions

If one accepts that kindness and its kindred, compassion and empathy are important to healthcare; and that a big part of that kindness is discretionary; then one has to contend with the ethical challenges this can pose. To see these more clearly, this paper has disaggregated kindness by viewing it through a principalist lens. This allows us to see that kindness properly comprises not just beneficence, but also respect for the person, non-maleficence and fairness. Otherwise, discretionary kindness can discriminate very effectively and appear blameless, by affording perks to insiders at unconsidered expense to outsiders. Worse still, misplaced kindness towards ingroup colleagues can lead them to close ranks and look after their own, even when aware that this malfeasance is causing harm to others. Beyond that, kindness can drive actions that override the autonomy of others, supposedly on the basis that to do so is in their best interests. In short, kindness can be widely deployed in ways that are unfair, harmful and/or paternalistic.

How then should we respond? A recent GMC consultation asked whether there ought to be a duty on doctors to be kind, courteous and respectful.⁴¹ We may be tempted by the apparent simplicity of framing within a duty, what should be defining qualities of a good doctor. But this approach may be problematic if it fails also to ensure that regulators and registrants are aware of the potential side-effects, where kindness commonly falls short of its ideal, as outlined in this paper. Second, there are practical concerns about how this would be judged and enforced. In seeking to uphold a separate ideal, that of public confidence in the medical profession, the GMC's enforcement may sometimes come across as unfair and Edwardian. The British Medical Association complained about a latest injustice as follows⁴²:

The fact that the GMC has effectively overturned Dr Arora's suspension shows that the current system is structurally disproportionate, with insufficient checks and balances, and is manifestly unjust. While this is the right response, it does not address the systemic flaws in the entire referral pathway to the GMC—ranging from the decision by an employer to refer, through to the decision to investigate, the process of investigation and finally the tribunal hearing. This is precisely why the BMA is calling for a root and branch independent evaluation of the entire GMC referral pathway. The immediate safeguard of an external scrutiny panel is needed to assess each potential employer referral to ensure that it is fair and objective, and consider whether the issue could be more appropriately dealt with locally and swiftly. Nothing less will secure justice or fairness in medical regulation.

At this juncture, it is therefore unclear whether the GMC would operate any better with a new duty to be kind. One might argue instead for a simpler duty against being unkind. While attractive (and perhaps already in place), this may still not address everyday situations in which kindness is invoked as a salve for what are nonetheless unwelcome and problematic actions. We may be better, instead, to concentrate on broadening the education of students and doctors.

One practical focus, for the GMC and other authorities within healthcare, should be what we might term *two-sided inclusion*. First, the inclusion of outgroups in the development of health policy and services is key. Together we can help see that discretionary kindness is distributed more fairly, its potential harms are mitigated more assiduously and its apparent imperatives are better considered with likely 'recipients'. Second, greater inclusion of ingroups as research subjects is required. This can move us away from the repeated and sometimes seemingly fruitless study of minoritised groups towards the proper study of majority groups. It can help us determine how ingroups manage kindness in healthcare; to help them understand how they more often attract discretionary benefits, employ discretionary silences and yet are heard over the interests of others.

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